		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155756	B. WING		11/26/2012
NAME OF F	DOLUDED OD GUDDI IEI		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	K	7843 V	V JEFFERSON BLVD	
COVENT	RY MEADOWS		FORT	WAYNE, IN 46804	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K0000					
	A Life Safety C	ode Recertification,	K0000	The creation and submission	of
	State Licensure			this Plan of Correction does no	ot
		k-thru Survey were		constitute an admission by this	
		the Indiana State		provider of any conclusion set forth in the statement of	
	Department of			deficiencies, or of any violation	n of
	-			regulation. This provider	. •.
	accordance wil	th 42 CFR 483.70(a).		respectfully requests that the	
	C D 1	11/26/12		2567 Plan of Correction be	
	Survey Date: 11/26/12 Facility Number: 004945			considered the Letter of Credi Allegation. This facility	bie
				respectfully requests a revisit	on
				or after December 26, 2012.	
	Provider Numb				
	AIM Number:	200814400			
	Surveyor: Amy	y Kelley, Life Safety			
	Code Specialis	t			
	At this Life Saf	ety Code survey,			
	Coventry Meac	dows was found not			
	in compliance	with Requirements			
	for Participatio	on in			
	Medicare/Med				
	•	O(a), Life Safety			
	<u> </u>	the 2000 edition of			
	the National Fi				
		FPA) 101, Life Safety			
	·	•			
		napter 18, New			
		ccupancies and 410			
	IAC 16.2.				
	This one story	facility was			
	-	be of Type V (111)			
				1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155756		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE : COMPL 11/26/	ETED	
	PROVIDER OR SUPPLIER	2	•	7843 W	DDRESS, CITY, STATE, ZIP CODE JEFFERSON BLVD VAYNE, IN 46804	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	alarm system videtection in the open to the cowired smoke diresident rooms capacity of 150 of 136 at the till. The facility was compliance with regard to spring smoke detector. All areas where customary accessive sprinklered. A facility services Quality Review by Code Specialist-Metal The facility was compliance with aforementione.	he facility has a fire with smoke e corridors, areas rridors and hard etectors in the s. The facility has a 0 and had a census ime of this survey. Is found in the state law in akler coverage and recoverage. It areas providing were sprinklered. Robert Booher, Life Safety edical Surveyor on 11/30/12.					

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Event ID: YQ0S21

Facility ID: 004945

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155756		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		X3) DATE SURVEY COMPLETED 11/26/2012			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0018 SS=E	NFPA 101 LIFE SAFETY CO Doors protecting constructed to re Doors are provide hardware. Dutch are permitted. R: 18.3.6.3 Based on obse interview, the fi ensure 1 of 2 r corridor doors closed and late frame. This de could affect 4 back smoke co 400 hall. Findings include Based on an ob Maintenance S Environmental 11/26/12 at 1 corridor door t 416 failed to la frame. The Ma acknowledged resident room	DDE STANDARD corridor openings are sist the passage of smoke. ed with positive latching doors meeting 18.3.6.3.6 coller latches are prohibited. rvation and facility failed to resident room on the 400 hall ched into the door eficient practice residents in the compartment of the de: coservation with the upervisor and the Supervisor on	K00		K 018 NFPA 101 Life Safety Code Standard It is the practic of this facility to ensure that all doors protecting corridor openings are provided with positive latching hardware. However, based on the allege deficient practice the following has been implemented: Wha corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice: The striker plate the door of room 416 on 400-h was replaced to ensure the do closed and latched into the doorframe. The striker plate w replaced on November 28 th , 2012. How will you identify other residents having the potential to be affected by th same deficient practice and what corrective action will be taken: All residents have th potential to be affected by the alleged deficient practice. Al resident room corridor doors w be tested prior to December 2	d t on nall oor vas e e e e	12/26/2012
	3.1-19(b)				to ensure they have positive latching hardware. What measures will be put into pla or what systemic changes w	ıce	

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Facility ID: 004945

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	01	COMPLETED		
		155756	B. WING		11/26/2012	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
				you make to ensure that the deficient practice does not recur: The striker plate or door of room 416 on 400-hal replaced to ensure the door closed and latched into the doorframe. The striker plate replaced on November 28 th 2012. The Maintenance Director or Designee will che resident room doors have polatching hardware on or befor December 26 th 2012. The Maintenance Director/Design will in-service all managers to monitor resident room doors ensure they have positive latter hardware. In-service will be completed by 12/26/12. The Maintenance Director is in chof program compliance. How the corrective action(s) will monitored to ensure the deficient practice will not refice, what quality assurance program will be put into plate. A CQI monitoring tool call Resident Room Doors will be utilized every week x 4, monity 3 and quarterly x 2. Data we collected by Maintenance Director/Designee and submet to the CQI committee. If threshold of 100% is not met action plan will be developed Non-compliance with facility procedures may result in disciplinary action up to and including termination. Completion	was was was ck all sitive re enee contonering enarge bw be ccur, cee: led enthly x viill be itted	
			I	Ī		

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155756	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMF	E SURVEY PLETED 6/2012	
NAME OF PI	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD				
	RY MEADOWS		FORT WAYNE, IN 46804				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH	IOULD BE PPROPRIATE	COMPLETION	

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Event ID: YQ0S21

Facility ID: 004945

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING O1 COMPLETE				
		155756	B. WIN			11/26/	2012
NAME OF P	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
WHILE OF T	KO VIDEK OK SOI I EIEK				JEFFERSON BLVD		
COVENT	RY MEADOWS			FORT V	WAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0025	NFPA 101 LIFE SAFETY CO	DDE STANDARD					
SS=D		re constructed to provide at					
		fire resistance rating in					
		8.3. Smoke barriers may					
		trium wall. Windows are					
	protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are						
		floor. Dampers are not					
	-	enetrations of smoke					
		ucted heating, ventilating,					
	and air conditionii						
	18.3.7.5, 18.1.6.3		K00	125	I/ 025 NEDA 404 Life Cofety		12/26/2012
	Based on obser		KUC	123	K 025 NFPA 101 Life Safety Code Standard		12/20/2012
	interview, the f	-			It is the practice of this facility	0	
	ensure 1 of 1 c	-			ensure all ceiling smoke barrie		
		aintained to provide			are maintained to provide a on	е	
		resistance rating.			hour fire resistance rating.	ı	
	-	ires smoke barriers			However, based on the alleged deficient practice the following	1	
	shall be contin				has been implemented:		
	outside wall to	an outside wall.					
	This deficient p	oractice was not in a			What corrective action(s) will		
	resident care a	rea but could affect			be accomplished for those residents found to have been		
	any number of	staff.			affected by the deficient		
					practice:		
	Findings includ	le:			P action		
	_				· The sprinkler head in the		
	Based on an ob	servation with the			rear dietary corridor was repair		
		upervisor and the			on December 10, 1012 to ensu there is no gap around the	ıre	
	Environmental	•			sprinkler head.		
		:00 p.m., a sprinkler					
	•	r dietary corridor			How will you identify other		
		and away from the			residents having the potential		
	-	· · · · · · · · · · · · · · · · · · ·			to be affected by the same		
		leaving a one half			deficient practice and what corrective action will be take	a:	
	inch gap aroun	d the sprinkler			Corrective action will be take	1.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155756	A. BUILDING B. WING		11/26/2012
				T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R			
001/51/7	:D\/ ME A D O\MO			W JEFFERSON BLVD	
COVENT	RY MEADOWS		FORT	WAYNE, IN 46804	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	head. The Ma	intenance			
				· All residents have the	
	<u> </u>	nfirm there was a		potential to be affected by the	
	_	gap around the		alleged deficient practice.	
	sprinkler head	at the time of		· All sprinkler heads were	
	observation.			checked on or before Decemb	per
				26 th to ensure no other gaps	
	3.1-19(b)			exist around sprinkler heads.	
	J.1-19(D)			\www.	.4-
				What measures will be put in	ito
				place or what systemic	
				changes you will make to	
				ensure that the deficient	
				practice does not recur	
				The sprinkler head in th	۵
				rear dietary corridor was repai	
				on December 10, 1012 to ens	
				there is no gap around the	
				sprinkler head	
				· All sprinkler heads be	
				monitored by the Maintenance	,
				Director/Designee on an on-go	
				basis to ensure there are no g	
				between the sprinkler heads a	ind
				the ceiling.	
				· The Maintenance	
				Director/Designee will in-servi	ce
				Maintenance Assistant on the	
				sprinkler head monitoring by	
				December 26, 2012. The Maintenance Direc	tor
				is in charge of program	lOi
				compliance	
				Compilario	
				How the corrective action(s)	
				will be monitored to ensure t	
				deficient practice will not red	
				i.e., what quality assurance	,
				program will be put into place	e:
				Fragram 20 par place	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155756	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 11/26/2012
	ROVIDER OR SUPPLIER	1	STREET A 7843 W FORT V	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION PRIATE DATE
				A CQI monitoring too called Sprinkler Head Gaps be utilized every month x 3 quarterly x 2. Data will be collected Maintenance Director/Design and submitted to the CQI committee. If threshold of 100% is not met, an action will be developed. Non-compliance with faprocedures may result in disciplinary action up to and including termination. Completion date: 12/26/20	s will and liby gnee f plan cility

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Facility ID: 004945

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING O1 COMPLETED			ETED	
		155756	B. WIN			11/26/2	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t			JEFFERSON BLVD		
COVENT	RY MEADOWS				VAYNE, IN 46804		
		TA TENTENT OF DEFICIENCIES	1			1	075)
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)					COMPLETION DATE
	NFPA 101	LISC IDENTIFTING INFORMATION)		TAG	DEFICIENCE,		DATE
K0051 SS=D	LIFE SAFETY CO	ODE STANDARD					
33-0	A fire alarm syste						
	components, devices or equipment is						
	•	ig to NFPA 72, to provide					
	effective warning	of fire in any part of the					
	_	on of the complete fire					
		by manual fire alarm					
	initiation, automa	•					
		tem operation. Pull					
	stations are located in the path of egress. Electronic or written records of tests are						
available. A reliable second source of power is provided. Fire alarm systems are							
	maintained in accordance with NFPA 72,						
		rm Code, and records of					
		kept readily available.					
		annunciation of the fire					
	18.3.4, 9.6	an approved central station.					
	Based on obse	nyation and	K00)51	K 051 NEDA 101 Life Safety		12/26/2012
			Koc	<i>)) 1</i>	K 051 NFPA 101 Life Safety Code Standard		12/20/2012
		facility failed to			It is the practice of this facility	to I	
		smoke detectors in			ensure smoke detectors are no		
	the main kitche	en was not installed			installed where air flow would		
	where air flow	would adversely			adversely affect the operation.		
	affect the oper	ation. NFPA 72,			However, based on the alleged		
	-	es in spaces served			deficient practice the following		
	·	systems, detectors			has been implemented:		
		cated where air flow					
					What corrective action(s) will	ı İ	
	prevents opera				be accomplished for those	-	
		s deficient practice			residents found to have been	,	
	was not in a re	sident care area but			affected by the deficient		
	could affect an	y number of staff.			practice:		
	Findings includ	de:			The smoke detector in t	he	
	3				main kitchen is scheduled to	,,,	
	Rased on obser	rvation with the			be moved on December 14, 20 away from the air supply duct		
	שמפנו טוו טשמפו	ו ימנוטוו שונוו נווכ			at least 3 feet.	y	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155756	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 11/26/2012		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION		
IAG	Maintenance S Environmental 11/26/12 at 2 kitchen had a s located eightee supply air duct	upervisor and the Supervisor on :03 p.m., the main smoke detector en inches from a :. Measurements by the Maintenance	IAG	How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be tated. All residents have the potential to be affected by the alleged deficient practice. All smoke detectors with checked by maintenance stored by maintenance stored by the alleged deficient practice. All smoke detectors with checked by maintenance stored by maintenance stored by maintenance stored by maintenance will be put place or what systemic changes you will make to ensure that the deficient practice does not recur: The smoke detector is main kitchen is scheduled to moved on December 14, 20 away from the air supply durat least 3 feet. All smoke detectors with moving moving by to ensure they have not been installed where airflow would adversely affecting the open. The Maintenance Director/Designee will in-set Maintenance Assistant on the smoke detector locations are monitoring by December 26 2012. The Maintenance Director is in charge of program	t ken: ene vill be aff on 12 to don. into In the p be 12 ct by vill be asis en do be ation. rvice ne end on,		
				_			

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	OF CORRECTION	IDENTIFICATION NUMBER: 155756	A. BUILDING B. WING	01 	COMPLETED 11/26/2012	
	PROVIDER OR SUPPLIEI	2	STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				How the corrective action(s) will be monitored to ensure to deficient practice will not reci.e., what quality assurance program will be put into place. A CQI monitoring tool called Smoke Detector Location will be utilized every month x and every quarter x 2. Data will be collected by Maintenance Director/Designer and submitted to the CQI committee. If threshold of 100% is not met, an action place will be developed. Non-compliance with facility procedures may result disciplinary action up to and including termination. Completion date: 12/26/2012	the cur, se: on 3 y see an in	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	A. BUILDING 01			COMPLETED	
		155756	B. WIN			11/26/	2012	
COVENT	PROVIDER OR SUPPLIEF	8	STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804					
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
K0062 SS=E	NFPA 101 LIFE SAFETY CO Required automa continuously main condition and are periodically. 18. NFPA 25, 9.7.5 Based on obse interview, the file ensure the sprinkler heads compartments LSC 9.7.5 requives sprinkler syste tested and main accordance with Standard for the Testing and Main Water-Based F Systems. NFPA 2-2.1.2 states obstructions to shall be correct practice could of the 200 hall residents in the Wellness Center	facility failed to ay pattern for s 3 of 10 smoke were unobstructed. ires all automatic ms be inspected, intained in th NFPA 25, ne inspection, aintenance of ire Protection A 25, Section unacceptable o spray patterns ted. This deficient affect any of the 33 residents, e New Energy er with a capacity of and 2 staff members.	K00)62	K 062 NFPA 101 Life Safety Code Standard It is the practice of this facility ensure the spray pattern for sprinkler heads are not obstructed. However, based the alleged deficient practice the following has been implemented. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The sprinkler head in the New Energy Wellness Center closet was repaired on Decem 10 th , 2012 so as the spray pattern of the sprinkler head we not be obstructed. The light fixture was mo away from the sprinkler head in the Maintenance Supervisor's office on November 28 th , 200 so as the spray pattern of the sprinkler head will not be obstructed.	on he ed: I e ber rill ved n	12/26/2012	
	Based on obse Maintenance S Environmental	rvation with the upervisor and			The light fixture was mo away from the sprinkler head i the 200 hall soiled utility room November 28 th , 2012 so as t spray pattern of the sprinkler head will not be obstructed.	n on		

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Event ID: YQ0S21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			î '			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED			
		155756	B. WIN			11/26/2012		
(F. 0F. P			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				7843 W JEFFERSON BLVD				
COVENTRY MEADOWS			FORT WAYNE, IN 46804					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX	· ·			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
	1:58 p.m., the	spray pattern for			How will you identify other			
	the following s	prinkler heads were			residents having the potentia	ll		
	obstructed:				to be affected by the same			
		r head had been			deficient practice and what corrective action will be take	n		
		he ceiling drywall in			Corrective action will be take	"		
	⁻	- · · · · · · · · · · · · · · · · · · ·			All residents have the			
	_	y Wellness Center			potential to be effected by the			
	closet,				alleged deficient practice.			
	,	sprinkler heads were			All sprinkler heads will be	II		
	located within	three inches of a			checked by maintenance staff	I		
	ceiling light fix	cture in the			or before December 26, 2012	II		
	Maintenance S	upervisor's office,			ensure their spray pattern of the sprinkler head will not be	ie		
		prinkler heads were			obstructed.			
		five inches of a		ossuusios.				
		cture in the 200 hall			What measures will be put in	to		
					place or what systemic			
	soiled utility ro				changes you will make to			
	This was confi	•			ensure that the deficient			
		upervisor at the			practice does not recur			
	time of observ	ations.				_		
	Measurements	were provided by			 All sprinkler heads will be monitored on an on-going basi 	I		
	the Maintenan	ce Supervisor.			to ensure their spray patterns	I		
		·			not be obstructed.			
	3.1-19(b)				· The Maintenance			
	J.1 15(b)				Director/Designee will in-service	ce		
					Maintenance Assistant on the			
					sprinkler head locations and			
					monitoring by December 26, 2012.			
					The Maintenance Direct	or		
					is in charge of program			
					compliance			
					How the corrective action(s)			
					will be monitored to ensure t	he		
					deficient practice will not rec	ur,		
					i.e., what quality assurance			
					program will be put into place	e:		
	I		- 1		I			

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	OF CORRECTION	IDENTIFICATION NUMBER: 155756	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 11/26/2012			
NAME OF P	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD					
COVENT	RY MEADOWS		FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	A CQI monitoring too called Sprinkler Head Inspension will be utilized monthly x 3 quarterly x 2. Data will be collected Maintenance Director/Designed submitted to the CQI committee. If threshold of is not met, an action plan with developed. Non-compliance with far procedures may result in disciplinary action up to an including termination. Completion date: 12/26/2	ol ection and d by gnee 100% vill be acility d			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BIIII	LDING	01	COMPL	ETED
	155756		B. WING 11/26/2012			2012	
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			7843 W JEFFERSON BLVD				
COVENTRY MEADOWS			FORT WAYNE, IN 46804				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
K0144 SS=F	NFPA 101 LIFE SAFETY CO Generators are in exercised under lemonth in accorda 3.4.4.1. Based on recordanterview, the frequire the load months indicated to accordance and temperature conducted und r 3-4.4. Tequires month generator service electrical system accordance with Standard for Enstandby Powers 6-4.2. Chapter 110 requires graph Level 1 and Leve exercised under temperature continuation in the standard for the minimum entry of the service of the minimum entry of the service of the servic	DDE STANDARD spected weekly and oad for 30 minutes per noce with NFPA 99. d review and acility failed to d testing for 7 of 12 ed a load test was er operating onditions, minimum imperatures or not ercent of the ng for the diesel gency generator set. 1.1 of NFPA 99 ally testing of the ng the emergency in to be in h NFPA 110, the mergency and is Systems, chapter of 6–4.2 of NFPA enerator sets in one 12 service to be ar operating onditions, maintains exhaust gas or not less than 30	K01		K 144 NFPA 101 Life Safety Code Standard It is the practice of this facility the ensure the generator is inspect weekly and exercised under low for 30 minutes per month. However based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On December 19 th MacAllister Inc. will in-service to Maintenance Department on the calculate the percentage of nameplate rating the generato was picking up under load however it has been determined that it could not be load tested meet State requirements. The facility then authorized MacAllister on the generator schedule for December 19 th , 2012. How will you identify other	to ted ad the ow the red to ster k	12/26/2012
	-	•			residents having the potentia	ıl	
	rating at least i				to be affected by the same		
) minutes. Chapter			deficient practice and what		
	3–5.4.2 of NFP	A 99 requires a			corrective action will be take	n:	
I			1		1		

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DIT	LDING	01	COMPL	ETED	
		155756	B. WING 11/26/2012			2012		
			Б. W II V		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF PROVIDER OR SUPPLIER				7843 W JEFFERSON BLVD				
COVENTRY MEADOWS				FORT WAYNE, IN 46804				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	written record of inspection,				· All residents have the			
	performance, e	exercising period			potential to be effected by the			
	and repairs for	the generator to be			alleged deficient practice.			
	regularly main	tained and available			On December 12 th			
	for inspection	by the authority			MacAllister Inc. in-serviced the			
		tion. This deficient			Maintenance Department on h			
		affect all resident in			to calculate the percentage of nameplate rating the generato			
	the facility.				was picking up under load	1		
	the raciney.				however it has been determine	ed		
	Eindings inclus	do:			that it could not be load tested			
	Findings includ	ie.			meet State requirements. The			
		Call Had all			facility then authorized MacAll to perform an annual load ban			
		w of the "Monthly		test on the generator scheduled				
	Load Test Log"				for December 19 th , 2012.	, u		
	Maintenance S	upervisor and the			·			
	Environmental	Supervisor on			What measures will be put in	ito		
	11/26/12 at 2	:37 p.m., the			place or what systemic			
	generator test	log showed a			changes you will make to			
	monthly load t	est for the past			ensure that the deficient practice does not recur:			
	twelve months but the log				practice does not recur.			
	indicated the g				· All load tests on the			
	operating at less than 30 percent				generator will meet the minimu	ım		
		ate rating for the			requirements as set forth by L			
	following mon				Safety Code Standards. The			
	_				test for the generator will be a annual load bank test conduct			
	=	ary, March, June,			by McCallister Inc. or designed			
		nd October. The			_			
		•			responsible for program			
	_	- · · · · · · · · · · · · · · · · · · ·			compliance.			
	generator did ı	not operate at 30			Have the same attres and or (-)			
	percent or more of the nameplate					ho		
	rating for the a	aforementioned						
	months.				-	,		
						e:		
	3.1-19(b)							
	Maintenance Stacknowledged generator did percent or morating for the amonths.	upervisor the emergency not operate at 30 re of the nameplate	· Maintenance Director is responsible for program					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01 COMPLETED					
		155756	B. WING		11/26/2012		
NAME OF P	PROVIDER OR SUPPLIER	-		ADDRESS, CITY, STATE, ZIP CODE			
		•		/ JEFFERSON BLVD			
COVENTRY MEADOWS			FORT WAYNE, IN 46804				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG				
				The Executive Director ensure the annual load bank t			
				is conducted to meet the life	esi		
				safety code requirements.			
				Non-compliance with			
				facility procedures may result	in		
				disciplinary action up to and			
				including termination.			
				Completion date: 12/26/2012	2		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING O1 COMPLETED					
		155756	B. WING 11/26/2012				
NAME OF PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
WANTE OF TROVIDER OR SOFTEELER			7843 W JEFFERSON BLVD				
COVENTRY MEADOWS			FORT WAYNE, IN 46804				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION		
PREFIX			PREFIX	CROSS-REFERENCED TO THE APPROPRIATE			
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
K0147 SS=D	NFPA 101 LIFE SAFETY C Electrical wiring accordance with Electrical Code. Based on obse interview, the ensure 1 of 1 as an extension as a substitute LSC 9.1.2 requand equipmen NFPA 70, Nation 1999 Edition. 400–8 require permitted, flex cables shall no substitute for structure. This could affect 2 on the 400 half eased on an o	ODE STANDARD and equipment is in NFPA 70, National 9.1.2 rivation and facility failed to flexible cords such on cord was not used of for fixed wiring. aires electrical wiring t to comply with conal Electrical Code, NFPA 70, Article s, unless specifically kible cords and of be used as a fixed wiring of a s deficient practice of the 22 residents II. de:	K0147	K 147 NFPA 101 Miscellaneo It is the practice of this facility ensure flexible cords are not u as a substitute for fixed wiring. However, based on the allege deficient practice the following was implemented: What corrective action(s) wil be accomplished for those residents found to have beer affected by the deficient practice: The lightweight extensic cord in room 410 was remover from the building. How will you identify other residents having the potentia to be affected by the same deficient practice and what corrective action will be take	us to seed		
	Maintenance Supervisor and the			· All residents have the			
	Environmental	Supervisor on		potential to be affected by the			
	11/26/12 at 1	2:48 p.m., a light		alleged deficient practice. All rooms will be checked	ad		
	weight extens	ion cord was		on or before December 26 th t			
	plugged in pro	oviding power to a		ensure no flexible cords are be			
	phone charger	in resident room		used as a substitute for fixed			
	410. The Maintenance Supervisor			wiring.			
		an extension cord		What measures will be put in	to		
	_	power to a phone		place or what systemic			
	i	•	1	1.			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION (X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155756	B. WIN			11/26/	2012
NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804				
(X4) ID	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG				PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	,			TAG	changes you will make to		DATE
	_			ensure that the deficient			
	the time of obs	servation.			practice does not recur:		
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Charger in resident room 410 at the time of observation. 3.1–19(b)				All rooms will be monito on an on-going basis to ensure no flexible cords are being use as a substitute for fixed wiring. The Maintenance Director/Designee will in-service all managers on the prohibited use of flexible cords being use as a substitute for fixed wiring December 26, 2012. The Maintenance Direct is in charge of program compliance How the corrective action(s) will be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into place. A CQI monitoring tool called Flexible Wiring will be utilized weekly x 4, monthly x 3 and quarterly x 2. Data will be collected by Maintenance Director/Designer and submitted to the CQI Committee. If threshold of 100 is not met, an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination. Compliance date: 12/26/2012	e ed	

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